



Name: _____

HEALTH QUESTIONNAIRE Address: _____
CT Coronary Angiogram

Further Details:

Date of birth: _____ Age: _____ Home ph: _____
Male Female Work ph: _____
Cardiologist: _____ Mobile ph: _____
Cardiologist office address: _____

Contrast Questions:

Background - contrast material is used to help highlight the important cardiac structure we are about to examine, and to improve the accuracy of the test you are about to undergo. Certain medical conditions may influence the way you react to the contrast material and it is important for the team to know these medical conditions before you proceed with this CT scan.

1. Are you pregnant or breastfeeding? Yes/No

2. Are you allergic to any medications? Yes/No
If so, what are they?.....

3. Have you had previous iodine based contrast or X-ray dye including CT scan, IVP/Kidney X-ray or angiogram ? Yes/No
Were there any problems? Yes/No
If so, please state.....

4. Are you being treated for diabetes? Yes/No
Do you take medications for diabetes? Yes/No
If so, please state.....

Do you take Metformin? Yes/No
(Diabex, Glucophage or Diaformin)

5. Have you ever been diagnosed with any of the following conditions:
- Asthma? Yes/No
 - Hyperthyroidism/Graves disease? Yes/No
 - Thyroid cancer? Yes/No
 - Pheochromocytoma? Yes/No
 - Myasthenia Gravis? Yes/No
 - Sickle cell disease? Yes/No
 - Kidney disease? Yes/No
 - Are you Hepatitis B or C positive? Yes/No

(Office Use Only Radiographer Initial.....)

General Questions

6. Do you have any of the following allergies? If yes, what type of reaction

Iodine/Contrast/Xray dye	Yes/No	_____
Latex	Yes/No	_____
Shellfish	Yes/No	_____
General allergies? If yes, to what?		_____

7. Which medications are you currently taking? (please attach a list if required)

8. General health

Current smoker <input type="checkbox"/>	Non smoker <input type="checkbox"/>
Ex-smoker < 12 mths <input type="checkbox"/>	Ex-smoker >12 mths <input type="checkbox"/>
Diabetes	Yes/No Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/>
High cholesterol	Yes/No
High blood pressure	Yes/No
Asthma/Airways disease	Yes/No
Regular exercise (30mins more than 3 days/week)	Yes/No
Do you have a family history of heart disease?	Yes/No
Post menopausal (females only)	Yes/No

9. Have you ever had:

Any cardiac surgery	Yes/No	Type _____	Year _____	Where _____
A heart attack	Yes/No		Year _____	
Abnormal stress test	Yes/No		Year _____	
Coronary angiogram	Yes/No		Year _____	
Stents placement/angioplasty	Yes/No		Year _____	
Pacemaker implant	Yes/No		Year _____	

10. This past week, have you had:

Chest pain/angina/chest tightness/pressure	Yes/No
Heart palpitations	Yes/No
Shortness of breath	Yes/No

11. Height _____ Weight _____ (Office Use Only RN Initial.....)

12. Do you require the assistance of an Interpreter? Yes/No
If yes, which language do you prefer? _____

Please return this form to MonashHeart ASAP before your appointment in the reply paid envelope provided or bring it in with you on the day.

Thank you

**Cardiac CT Services
MonashHeart
Southern Health**